Why the mechanisms of 12-Step behaviour change should matter to clinicians

BEST, David <http://orcid.org/0000-0002-6792-916X>

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David Best
Department of Law and Criminology, Sheffield Hallam University, Sheffield, United Kingdom
Email: D.Best@shu.ac.uk

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The effective elements of 12-step largely align with principles of professional treatment and with recovery models. Professional addiction workers should review their own barriers to promoting AA to clients.

Kelly (1) has produced a rigorous, sound and clear review of the mechanisms of behaviour change involved in AA. He concludes that a 'spiritual awakening' is relatively uncommon and that the majority of the benefits arise from "social, cognitive and affective mechanisms". He concludes that "to dismiss AA as a potentially effective addiction recovery support option on the grounds that it is spiritual or religious and therefore unscientific is inconsistent with the body of rigorous research accumulated during the past 25 years".

Why is this a concern? In both the UK (2) and Australia (3) professional addiction workers have been characterised as often being sceptical about, and dismissive of, 12-step mutual aid groups (as well as having little personal contact with, and low levels of knowledge about, mutual aid). Much of this concern relates to the 'God' component and the idea that there is a fundamental incompatibility between 12-step and evidence-based practice. This is linked to a wider concern, in a section of the drug and alcohol workforce, that recovery is a messianic movement for temperance and what is referred to in Australia as 'wowserism' - the killjoy spirit that is seen to be a part of the abstinence commitment of recovery.

What the three key 'mechanisms' papers reviewed (4, 5, 6) show is that AA is primarily effective by creating positive social network change and by increasing abstinence self-efficacy, and that spiritual awakening is a relatively uncommon experience. Given what is known about the 'additive' benefits of mutual aid groups delivered alongside specialist 'professional' treatment, there is a core message here for workers about the compatibility of AA and alcohol treatment and about the underlying mechanisms. This is particularly important in a time of the global financial crisis when mutual aid represents a mechanism for increasing positive social networks when specialist treatment and 'therapist' support are not available.

Additionally, and central to broader models of recovery (7, 8), mutual aid provides a mechanism for extending the reach of positive change from the clinic to the community through both personal and social recovery capital (9). Nonetheless, many professional drug and alcohol workers have an adversarial attitude to 12-step and to recovery concepts more generally (10), considering them to be almost cult-like and dangerous as a result of a lack of professional regulation compounded by fears

of unholy influences of higher powers and undue personal influence. Challenging such myths is essential if helping agencies are to take advantage of what Kelly refers to as "the closest thing we have to a free lunch in public health".

Providing strong scientific evidence of the mechanisms of action based on consistent evidence about effect sizes and variability in effectiveness across populations will go some way to addressing the concerns of the scientific and policy communities, but translating that credibility to front-line workers is a much more complex task that must involve changes in the way mutual aid is presented in professional training and development. It must also involve greater actual exposure. In both the Australian and UK studies mentioned at the start of this commentary (2,3), levels of personal attendance at 12-step meetings by addiction professionals were low and poor attendance was associated with poorer knowledge and more negative attitudes. This represents a form of stigmatisation that can only be addressed through exposure.

The evidence presented by Kelly is clear and workers who continue to discourage their clients from attending AA groups and who eschew the philosophy need not only a better understanding of how and why AA (and other mutual aid groups) work, but also a recognition that there are common mechanisms of effective behaviour change that can be tackled through the simultaneous engagement in specialist treatment and community-based mutual aid.

Further, there remains an opportunity to enter a debate with which many addiction scientists are reluctant to engage - which is what do we mean by spirituality? As Kelly acknowledges, our definitions have typically been narrow and there may well be components of basic human connection (in mutual aid groups, group therapy and individual counselling) which have a fundamentally 'spiritual' component that is nothing to do with God.

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